

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09064

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>39 Cristfield</u>	LENGTH OF STAY (in this place) <u>15 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>37 Cristfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walnut St.</u>		STREET ADDRESS (If rural give location) <u>Walnut St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mannie Abbott</u>		DATE OF DEATH: <u>Sept. 28</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 18, 1904</u>
9. AGE last birthday <u>51</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Marine Railway</u>	
11. BIRTHPLACE (State or foreign country): <u>Deal Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Abbott</u>		14. MOTHER'S MAIDEN NAME: <u>Frances Laird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-16-9423</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Amy Abbott - Cristfield, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.1 Acute Myocardial Infarction</u>			<u>5 minutes</u>
ANTECEDENT CAUSE (B) <u>260x</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 15</u> , 19 <u>53</u> , to <u>Aug. 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 27</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> P. M. from the causes and on the date stated above.			
SIGNATURE <u>A. N. Baw</u>		DATE SIGNED <u>9/30/55</u>	
ADDRESS <u>Cristfield, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cristfield, Md.</u>	
24. FUNERAL DIRECTOR <u>Bradshaw & Sons</u>		ADDRESS <u>Cristfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Barbara L. Adams</u>	

RECEIVED

OCT 6 1955

BUREAU V. S.

9055

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Weston</u>	LENGTH OF STAY (in this place) <u>16 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Weston</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		STREET ADDRESS (If rural give location) <u>Rural</u>	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Melvin J Baker</u>		DATE OF DEATH: <u>Sept. 29 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 20, 1896</u>
9. AGE last birthday: <u>59</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country): <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John E. Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Minnie J. Baker Weston</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of rectum</u>			
ANTECEDENT CAUSE (B) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11/1/54</u> , 19 <u>54</u> , to <u>9/29/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/2/55</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>William H. Johnson</u>		DATE SIGNED <u>9-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holly Grove</u>		LOCATION (City, town, or county) (State) <u>Weston Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/30/55</u>		REGISTRAR'S SIGNATURE <u>R. W. Johnson, M.D.</u>	
24. FUNERAL DIRECTOR <u>Henry H. Watson</u>		ADDRESS <u>Cocoma, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 3 1955

RECEIVED

9-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 09066

No. 760

1. PLACE OF DEATH:

COUNTY Somerset MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) Rural Queen Anne, Rural LENGTH OF STAY (in this place) 4 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY SomersetCITY (If outside corporate limits write RURAL and give nearest town) Rural Queen Anne OR TOWN Rural Queen Anne XSTREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ClarenceBrown

4. DATE OF DEATH

(Month)

(Day)

(Year)

Sept 1819 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Malecolored19183737373710a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer10b. KIND OF BUSINESS OR INDUSTRY: Same Labor11. BIRTHPLACE (State or foreign, country): Georgia, Valdosta?12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

Not Known

14. MOTHER'S MAIDEN NAME:

Not Known15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no16. SOCIAL SECURITY No.: 267-05-1657

17. INFORMANT & ADDRESS:

Will James Brown Anne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) acute coronary heart disease

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) died when I saw him

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH 3 hours

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

R. J. JohnsonCHIEF MEDICAL EXAMINER ☐

DATE SIGNED

M. D. DEPUTY MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAM. ☐Sept 21-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9/21/55R. J. Johnson, M.D.William A. James Jr. Princess Anne Md

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9057

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09067

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>VENTON</u>		LENGTH OF STAY (in this place) <u>8 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>VIENNA MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>02</u>				STREET ADDRESS (If rural give location) <u>09X-2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM</u> <u>BYRD</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>9</u> <u>4</u> <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>?</u> <u>1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>labor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>factory canning</u>		11. BIRTHPLACE (State or foreign country): <u>VENTON MD. SOMERSET COUNTY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>MORRIS BYRD</u>				14. MOTHER'S MAIDEN NAME: <u>MARY PARKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>220-10-6655A</u>		17. INFORMANT & ADDRESS: <u>ELIZABETH ROBINSON. PRINCESS ANNE MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>						<u>18 months</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>in - Sept. 4</u>			
22. I hereby certify that I attended the deceased from <u>July 27, 1955</u> , to <u>Sept. 4, 1955</u> , that I last saw the deceased alive on <u>Aug 31</u> , 1955, and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. G. Harrison</u>		M.D.		ADDRESS <u>Princess Anne Md</u>		DATE SIGNED <u>9-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>GRACE</u>		LOCATION (City, town, or county) (State) <u>VENTON MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/7/55</u>		REGISTRAR'S SIGNATURE <u>R. S. Johnson M.D.</u>		24. FUNERAL DIRECTOR <u>W. H. Jones</u>		ADDRESS <u>Princess Anne Md</u>	

BUREAU V. S.

SEP 8 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09068
 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		lifetime		TOWN Crisfield		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 McCready Hospital				Paper St. 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
CHARLES DENNIS				OF DEATH: September 18 19 55			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: Dec. 8, 1939	
				9. AGE last birthday: 15 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none				10B. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Irvington, Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Wilbur Smith				14. MOTHER'S MAIDEN NAME: Ella Dennis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
401.8 IMMEDIATE CAUSE (A) Rheumatic Pancarditis						10 days	
ANTECEDENT CAUSE (B) Rheumatic Fever						1 1/2 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 12, 1955, to Sept. 18, 1955, that I last saw the deceased alive on Sept. 18, 1955, and that death occurred at 3:15a.M. from the causes and on the date stated above.							
SIGNATURE C. Rawley				ADDRESS Crisfield, Md.		DATE SIGNED 9/20/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 20, 1955		Lawsonia Cemetery		Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 20, 1955		Barbara L. Adams		Bradshaw & Sons—Crisfield, Md.			

BUREAU V. S.

SEP 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09069

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crisfield		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crisfield		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS McCreedy Hospital				STREET ADDRESS (If rural give location) Crockett Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) Belle Zora Evans				4. DATE OF DEATH: (Month) (Day) (Year) Sept. 13, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: Aug. 31, 1881	
9. AGE last birthday: 74 yrs.		10. MONTHS: 0		11. HOURS: 12		12. MIN: 12	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: John Maddrix				14. MOTHER'S MAIDEN NAME: Jane Somers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): No		16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Vernon Evans, Crisfield, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
900.0 Immediate cause (a) acute dil of heart DUE TO Antecedent causes (s) (b) Fractured rt. femur Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
Interval Between Onset And Death: 1 month							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. diabetes mellitus							
19a. DATE OF OPERATION: Sept. 1, 55							
19b. MAJOR FINDINGS OF OPERATION: Complete fracture upper third rt femur							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE accident		PLACE (Home, farm, factory, street, OF office bldg., etc.) home		(CITY OR TOWN) Crisfield		(COUNTY) (STATE) Somerset Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY Aug 18, 55 5A m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Fall down steps at home			
22. I hereby certify that I attended the deceased from Aug 18, 1955 , to Sept 13, 1955 , that I last saw the deceased alive on Sept 13, 1955 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.							
SIGNATURE C. Rawley		(Degree or title) md.		ADDRESS Crisfield Md		DATE SIGNED 9/15/55	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF Sept. 15, 1955		NAME OF CEMETERY OR CREMATORY Crisfield		LOCATION (City, town, or county) (State) Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR Sept. 15, 1955		REGISTRAR'S SIGNATURE Barton S. Adams		24. FUNERAL DIRECTOR Durward Q. Covington, Crisfield, Md.			

RECEIVED

SEP 19 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

960 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09070

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write TOWN and give nearest town)		RURAL OR TOWN		CITY (If outside corporate limits, write TOWN and give nearest town)		RURAL OR TOWN	
Crisfield		4 days		Crisfield		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
McCreedy Hospital				Chesapeake Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
FERNANDO CORTEZ HEADLEY				September 15 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Married		Jan. 8, 1881	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.	
74 yrs.		Months		Days		Hours	
74		74		74		74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
seafood packer				Seafood Industry			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Northumberland County, Va.				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Headley				Sarah Winstead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.			
no							
17. INFORMANT & ADDRESS:				122 Maryland Ave.			
Mrs. Helen Christy Neilson- Crisfield, Md.							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma - Mandible							
ANTECEDENT CAUSE (B) 2 years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar , 19 49 to Sept , 19 55 , that I last saw the deceased alive on Sept 15 , 19 55 , and that death occurred at 9:35p.M. from the causes and on the date stated above.							
SIGNATURE C. R. Rowley M.D.				DATE SIGNED 9/17/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
Burial				Crisfield Cemetery			
DATE REC'D BY LOCAL REGISTRAR 9/17/55				24. FUNERAL DIRECTOR ADDRESS Bradshaw & Sons-Crisfield, Md.			

RECEIVED

SEP 21 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09071

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Summerset</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Del.</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chance</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ocean View</u> 46X-3	
TOWN <u>Chance</u>		TOWN <u>Ocean View</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chance</u>		STREET ADDRESS (If rural, give location) <u>Ocean View</u>	
3. NAME OF DECEASED (First) <u>Thomas</u> (Middle) <u>H.</u> (Last) <u>Hudson</u>		4. DATE OF DEATH (Month) <u>9/6</u> (Day) <u>1955</u> (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 17, 1869</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technical Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Preaching</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Effie Hudson Ocean View, Del.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Coronary thrombosis</u>		Seconds	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u>		Years	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) <u>Ocean View</u> (COUNTY) <u>Del.</u> (STATE) <u>Del.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-4</u> , 19 <u>55</u> , to <u>9-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>55</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Everett C. Sutter M.D.</u>		ADDRESS <u>Queen, Queen, Maryland</u>	
DATE SIGNED <u>9/9/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>9/9/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) <u>Ocean View, Del.</u>	
DATE REC'D BY LOCAL REG. <u>9/6/55</u>		REGISTRAR'S SIGNATURE <u>Lala J. Whealley</u>	
24. FUNERAL DIRECTOR <u>Wm. Howard Wells</u>		ADDRESS <u>Pittsville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55-
86
69

BUREAU V. S.

SEP 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09072

CERTIFICATE OF DEATH

Reg. Dist. No. 360

962

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fairmount</u>		LENGTH OF STAY (in this place) <u>8 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairmount</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Orison M. Hurd</u>				OF DEATH: <u>Sept 27</u> 19 <u>55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>widowed</u>	8. DATE OF BIRTH: <u>Oct. 20, 1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired from U.S. Army</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Alfred P. Hurd</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Armond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes war 1 & 2</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Marion Mezzetti Fairmount,</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Cystitis. Uremia</u>						<u>8 mo</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Benign Prostatic Hypertrophy</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>						<u>8 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 30, 1955</u> , to <u>Sept 25, 1955</u> , that I last saw the deceased alive on <u>Feb 28, 1955</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. N. Bam</u>				ADDRESS <u>Cumflet, Md.</u>		DATE SIGNED <u>9/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 1, 1955</u>		<u>Brookside Cemetery</u>		<u>Englewood, N.J.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9/28/55</u>		<u>K. S. Johnson, M.D.</u>		<u>Lewis R. Wilson</u>		<u>Princess Anne, Md.</u>	

BUREAU V. 8

NOV 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

11225

Reg. Dist. No. 260

1. PLACE OF DEATH- COUNTY Somerset CITY (If outside corporate limits, write RURAL and OR give nearest town) Fairmount HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Somerset CITY (If outside corporate limits, write RURAL and give nearest town) Fairmount STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Issac (First) J. (Middle) Maddox (Last)		4. DATE OF DEATH (Month) Sept (Day) 19 (Year) 1955	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, married	8. DATE OF BIRTH April 15, 1882 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY laborer	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John D. Maddox		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		17. INFORMANT Bebecca Maddox Fairmount, Md.	

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 933.8 Immediate cause (a) Starvation and exposure - wandered away from home into marsh on September 14, 1955 - Body found November 22, 1955			INTERVAL BETWEEN ONSET AND DEATH ?
Antecedent cause(s) (b) September 14, 1955 - Body found November 22, 1955			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE) (19)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE R. S. Johnson M.D.		DATE SIGNED Nov 30-55	
23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		DATE THEREOF II-30-1955	NAME OF CEMETERY OR CREMATORY Odd Fellow cemetery
LOCATION (City, town, or county) Fairmount, Md.		(State)	
24. FUNERAL DIRECTOR Lewis R. Wilson		ADDRESS Princess Anne, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09073

9-63

CERTIFICATE OF DEATH

Reg. Dist. No. 760

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR TOWN <u>Princess Anne</u>)	LENGTH OF STAY (in this place) <u>2 1/2 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Princess Anne Md</u>)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt 3, Box 205</u>		STREET ADDRESS (If rural give location) <u>Rt 3 Box 205</u>	
3. NAME OF DECEASED: (First) <u>Feathera</u> (Middle) <u>G</u> (Last) <u>Maddock</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>9-19-1955</u>	
5. SEX: <u>female</u>	6. COLOR OF HAIR: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>8-22-1904</u>
9. AGE last birthday <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>19</u> Hours <u>19</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>House Work</u>	
11. BIRTHPLACE (State or foreign country): <u>Somerset</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Bewins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>?</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>228-83-8182</u>	
17. INFO. MAINT. & ADDRESS: <u>Cleming Maddock</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>170X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO <u>Carcinoma of liver + stomach</u>		6 mos.	
(B) DUE TO <u>Carcinoma of breast</u>		1 yr.	
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary Anemia</u>			
19A. DATE OF OPERATION: <u>8</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-17-1955</u> to <u>9-17-1955</u> , that I last saw the deceased alive on <u>9-17-1955</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. L. Lewis</u>		DATE SIGNED <u>9/19/55</u>	
M. D. <u>Princess Anne, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St John</u>		LOCATION (City, town, or county) <u>Seale</u>	
(State) <u>Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>9/20/55</u>		REGISTRAR'S SIGNATURE <u>R. S. Johnson, M.D.</u>	
24. FUNERAL DIRECTOR <u>William A. Jansoff</u>		ADDRESS <u>Princess Anne Md</u>	

BUREAU V. 2

SEP 22 1955

RECEIVED

9-64

09074

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Princess Anne</u>				OR TOWN <u>Princess Anne</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Route 2 - Box 157		STREET ADDRESS (If rural, give location)			
				Route 2 - Box 157			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH			
(Type or Print)		<u>George Alfred Saul</u>		September 6, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>Mar. 7, 1938</u>	<u>17</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Trucking</u>		<u>Helper</u>		<u>Princess Anne, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Martin Saul</u>				<u>Lena Bivens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)		<u>214-34-5273</u>		<u>Lena Bivens - Rt. 2 - Princess Anne, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Anoxemia secondary to</u> DUE TO Antecedent cause(s) (b) <u>Aspiration 3rd - diagnosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>determined after Autopsy by Dr. W. Terry</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None</u>)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 6 - 1955 6:20 AM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Probably from regurgitation of food from stomach</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>R. E. Johnson</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>Sept 7 - 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>9/8/55</u>		<u>St. Mary's Cem.</u>	
DATE REC'D BY LOCAL REG. <u>9/9/55</u>		REGISTRAR'S SIGNATURE <u>R. E. Johnson, M.D.</u>		24. FUNERAL DIRECTOR ADDRESS <u>William H. Jones Jr. Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

THIS FORM IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON IN CHARGE OF THE DEPARTMENT OF HEALTH OF THE STATE IN WHICH THE DEATH OCCURRED. IT IS TO BE FURNISHED TO THE BUREAU OF VITAL STATISTICS OF THE UNITED STATES DEPARTMENT OF HEALTH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Name]		2. PLACE OF BIRTH [Place]	
3. SEX [Sex]		4. AGE [Age]	
5. OCCUPATION [Occupation]		6. COLOR OF EYES [Color]	
7. COLOR OF HAIR [Color]		8. COLOR OF SKIN [Color]	
9. DATE OF DEATH [Date]		10. TIME OF DEATH [Time]	
11. PLACE OF DEATH [Place]		12. CAUSE OF DEATH [Cause]	
13. MEDICAL EXAMINATION [Examination]		14. SIGNATURE OF PHYSICIAN [Signature]	
15. SIGNATURE OF MEDICAL EXAMINER [Signature]		16. SIGNATURE OF DEATH REGISTRAR [Signature]	
17. SIGNATURE OF DEATH REGISTRAR [Signature]		18. SIGNATURE OF DEATH REGISTRAR [Signature]	
19. SIGNATURE OF DEATH REGISTRAR [Signature]		20. SIGNATURE OF DEATH REGISTRAR [Signature]	
21. SIGNATURE OF DEATH REGISTRAR [Signature]		22. SIGNATURE OF DEATH REGISTRAR [Signature]	
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87. SIGNATURE OF DEATH REGISTRAR [Signature]		88. SIGNATURE OF DEATH REGISTRAR [Signature]	
89. SIGNATURE OF DEATH REGISTRAR [Signature]		90. SIGNATURE OF DEATH REGISTRAR [Signature]	
91. SIGNATURE OF DEATH REGISTRAR [Signature]		92. SIGNATURE OF DEATH REGISTRAR [Signature]	
93. SIGNATURE OF DEATH REGISTRAR [Signature]		94. SIGNATURE OF DEATH REGISTRAR [Signature]	
95. SIGNATURE OF DEATH REGISTRAR [Signature]		96. SIGNATURE OF DEATH REGISTRAR [Signature]	
97. SIGNATURE OF DEATH REGISTRAR [Signature]		98. SIGNATURE OF DEATH REGISTRAR [Signature]	
99. SIGNATURE OF DEATH REGISTRAR [Signature]		100. SIGNATURE OF DEATH REGISTRAR [Signature]	

RECEIVED
SEP 8 1914
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-65 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09075

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Princess Anne</u>		<u>Life</u>		TOWN <u>Princess Anne</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>00</u>				<u>Somerset Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Wesley H. Skremer</u>				DEATH: <u>Sept 14 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
				<u>Widowed</u>		<u>Dec 16, 1886</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>68</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Radio Operator</u>						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Woodland. Furman.</u>				<u>Edna Austin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9</u>						<u>Mrs. Brady Skremer</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
(A) <u>Cerebro-vascular accident</u>						<u>20 minutes</u>	
DUE TO							
ANTECEDENT CAUSE (S)							
(B) <u>Hypertensive arteriosclerotic</u>						<u>10 yrs +</u>	
DUE TO							
(C) <u>cardio-vascular</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Renal calculus with vomiting</u>						<u>4 hours</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-29</u> , 19 <u>54</u> , to <u>9-14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>55</u> , and that death occurred at <u>10⁰⁰</u> P.M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Geo M. Blum</u>		<u>M. D. Brinnen Anne Md.</u>		<u>9-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>9/17/55</u>		<u>Maroon Presbyterian</u>		<u>Princess Anne Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR, ADDRESS			
<u>7/6/55</u>		<u>R. Z. Johnson, M.D.</u>		<u>James Newman</u>		<u>Princess Anne Md.</u>	

RECEIVED

SEP 19 1955

BUREAU V. 1

966

CERTIFICATE OF DEATH

Reg. Dist. No. 265...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		1 day		OR TOWN Crisfield		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
79 McCready Hospital				Lawsonia Section 1			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) CHARLOTTE		(Middle)		(Last) STERLING		OF DEATH: September 24 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Married		August 30, 1892	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
63 yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife				10B. KIND OF BUSINESS OR INDUSTRY: Domestic			
11. BIRTHPLACE (State or foreign country): Philadelphia, Penna.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: William A. Gundaker				14. MOTHER'S MAIDEN NAME: Matilda Winkleman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT & ADDRESS: Lawsonia Section Stoughton Sterling, Sr.—Crisfield, Md.							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) Coronary thrombosis							immediate
ANTECEDENT CAUSE (B) Cerebral thrombosis							15 hrs -
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive arteriosclerotic heart disease							years.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 9, 1951., to Sept 24, 1955, that I last saw the deceased alive on Sept 24, 1955, and that death occurred at 7:30 P M, from the causes and on the date stated above.							
SIGNATURE C. R. Crowley				M. D. Crisfield Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 27, 1955		Private Sterling Cemetery		Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 26, 1955		Barbara L. Adams		Bradshaw & Sons--Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

1955 OCT 8

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

954

CERTIFICATE OF DEATH

Reg. Dist. No.

09077

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL OR and give nearest town) 39 Crisfield	LENGTH OF STAY (in this place) lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 39 Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Lawsonia Section		STREET ADDRESS (If rural give location) 1 Lawsonia Section	
3. NAME OF DECEASED: (First) LENA (Middle) MAY (Last) TYLER		4. DATE (Month) (Day) (Year) OF DEATH: September 24 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: October 17, 1914
9. AGE last birthday 40 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none		10B. KIND OF BUSINESS OR INDUSTRY: none	
11. BIRTHPLACE (State or foreign country): Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William H. Tyler		14. MOTHER'S MAIDEN NAME: Addie M. Lawson	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: R.F.D. Lawsonia William H. Tyler-- Crisfield, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 753.1		6 mos.	
ANTECEDENT CAUSE (S)		lifetime	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Cerebral lesion			
(B) Underdevelopment of Cerebrum			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June , 1955, to Sept. 24 , 1955, that I last saw the deceased alive on Sept. 22 , 1955, and that death occurred at 1 P. M, from the causes and on the date stated above.			
SIGNATURE Samuel M. Peyton		DATE SIGNED 9/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 26, 1955	
NAME OF CEMETERY OR CREMATORY Asbury Cemetery		LOCATION (City, town, or county) (State) Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR Sept. 26, 1955		REGISTRAR'S SIGNATURE Bartow L. Adams	
24. FUNERAL DIRECTOR		ADDRESS Bradshaw & Sons--Crisfield, Md.	

RECEIVED

SEP 28 1955

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09078

9-67

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Crisfield</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>McCreedy Hospital</u>				STREET ADDRESS (If rural give location)		1	
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Harvie James Hard</u>				OF DEATH: <u>9</u> <u>19</u> <u>1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married Jan 2, 1917</u>		8. DATE OF BIRTH:	
				9. AGE last birthday <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Seaman</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Crisfield, Sam. Co.</u>	
13. FATHER'S NAME: <u>Willie Hard</u>				14. MOTHER'S MAIDEN NAME: <u>Minnie Cottman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>no.</u>				16. SOCIAL SECURITY No. <u>216-01-6661</u>		17. INFORMANT & ADDRESS: <u>Cora Hard-Marion Sta., Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>acute Dil. of heart</u>			
DUE TO <u>Verus pneumonia</u>			
ANTECEDENT CAUSE (S) <u>Verus endocarditis</u>			
DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocarditis</u>			

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep. 14, 1955, to Sep. 19, 1955, that I last saw the deceased alive on Sep. 19, 1955, and that death occurred at 11:55 PM, from the causes and on the date stated above.

SIGNATURE <u>George E. Coulburn</u>	ADDRESS <u>M. D. Mariani Sta. 2nd</u>	DATE SIGNED <u>Sep. 22, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Sept 25, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Wesley Family cemetery</u>
LOCATION (City, town, or county) (State) <u>Marion Sta., Md. Som. Co.</u>	DATE REC'D BY LOCAL REGISTRAR <u>Sep. 22, 1955</u>	REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>
24. FUNERAL DIRECTOR <u>Chas. H. Hard</u>	ADDRESS <u>Marion Sta., Md.</u>	# <u>225</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 28 1955

RECEIVED

9-68

CERTIFICATE OF DEATH

Reg. Dist. No. 090780

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rural Princess Anne</u>		<u>Life</u>		TOWN <u>Rural Princess Anne</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Morris Page Ward</u>				<u>Sept 21 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>Nov 11 1890</u>	
9. AGE last birthday: <u>64</u> yrs.		10. UNDER 1 YEAR		11. UNDER 24 HRS.		12. IF UNDER 24 HRS.	
Months		Days		Hours		Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>md</u>	
13. FATHER'S NAME: <u>Benjamin Ward</u>				14. MOTHER'S MAIDEN NAME: <u>Marcella Knox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Dr. Everett C. Sutter James Frederick md</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
223X IMMEDIATE CAUSE (A) <u>Brain Tumor</u>							Months
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchial asthma</u>							Years
19A. DATE OF OPERATION: <u>June 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>brain tumor</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-20</u> , 1955, to <u>9-21-55</u> 19, that I last saw the deceased alive on <u>9-21</u> , 1955, and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Everett C. Sutter</u>				ADDRESS			
DATE SIGNED <u>9-22-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>9/24/55</u>		<u>Allen Cemetery</u>		<u>Allen md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9/26/55</u>		<u>R. E. Johnson, M.D.</u>		<u>James Newman</u>		<u>Princess Anne md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 28 1955

RECEIVED

9-69

CERTIFICATE OF DEATH

Reg. Dist. No. 265...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Rehobeth		LENGTH OF STAY (in this place) lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rehobeth		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) HARRIET (Middle) WHITTINGTON (Last)				4. DATE (Month) (Day) (Year) OF DEATH: September 24 19 55			
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houswife				10B. KIND OF BUSINESS OR INDUSTRY: Domestic		11. BIRTHPLACE (State or foreign country): R.F.D. Marion, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: unknown				14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: John Henry Whittington—Rehobeth, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Disease							
ANTECEDENT CAUSE (B) arterio Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Coronary Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: no		19B. MAJOR FINDINGS OF OPERATION no				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955 to 1955 , that I last saw the deceased alive on no 19 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. SIGNATURE Myrtle Boulbourn ADDRESS Crisfield Md DATE SIGNED Sept 26-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 27, 1955		NAME OF CEMETERY OR CREMATORY Marumsco Cemetery		LOCATION (City, town, or county) (State) Marumsco, Md.	
DATE REC'D BY LOCAL REGISTRAR Sept. 26, 1955		REGISTRAR'S SIGNATURE Barbara S. Adams		24. FUNERAL DIRECTOR Bradshaw & Sons—Crisfield, Md.		ADDRESS	

BUREAU V.

SEP 28 1955

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